Medical Marijuana Transfer Authorization Form

To be completed and signed by the OMMP Patient

MEDICAL MARIJUANA DISPENSARY PROGRAM

Patient Name*	Phone Number*	OMMP Number*	Expiration Date*

**Required information*

As the patient, I authorize my excess usable marijuana and/or immature plants to be transferred on my behalf to the following dispensary:

Dispensary Name*	Apothecaria	Address*	700 Row River Rd., Cottage Grove OR 97424

**Required information*

Authorizations: *(check all that apply)*

I authorize **myself** to transfer: ☒ usable marijuana ☐ immature plants

☐ I authorize my **Caregiver** to transfer to this dispensary

Caregiver Name*	Phone Number*	OMMP Number*	Exp. Date*	May Transfer* Usable Marijuana	May Transfer* Immature Plants
				☐	☐

**If the Caregiver is authorized, this information must be provided.*

☐ I authorize my **Grower** to transfer to this dispensary

Grower Name*	Phone Number*	OMMP Number*	Exp. Date*	May Transfer* Usable Marijuana	May Transfer* Immature Plants
				☐	☐

**If the Grower is authorized, this information must be provided.*

Any person may not transfer more than 24 ounces or 18 immature plants at any one time.

This authorization is valid until: ☒ my OMMP card expires ☐ date: _____

or until this authorization is revoked by me, whichever is soonest. I understand that the product will no longer be my property after transfer is complete, and that it will be returned to me if it tests positive for pesticides, mold, or mildew.

_____ _____

Patient Signature Date

_____ _____

PRF Signature Date

Colleen Valley

PRF Name

The facility must keep the original copy of this form on file.
The patient and the person they authorize, if applicable, should keep a copy of the form for their records.